CATAMOUNT HEALTH
FREQUENTLY ASKED QUESTIONS

OVERVIEW OF CATAMOUNT HEALTH

Q: What is Catamount Health?
A: Catamount Health is a new health insurance plan that is available starting October 1, 2007 for uninsured Vermonters. It offers comprehensive, affordable and quality benefits with low co-payments and premiums no matter how much you earn. The plan is offered, in cooperation with the state of Vermont, by Blue Cross Blue Shield Vermont and MVP.

Q: What services does Catamount Health cover?
A: Catamount Health has comprehensive and quality coverage which includes doctor visits, check ups, screenings, acute episodic care, preventive care, hospital visits and emergency care, care for chronic diseases, prescription medicines and more.

Q: How much does Catamount Health cost?
A: Catamount Health's co-payments and premiums cost less than other health plans with comprehensive benefits. The monthly cost will depend on your income and which insurer you choose. Deductibles start at $250, depending on the size of your family and whether you go to a doctor who is in the Catamount Health network. Co-payments for office visits are $10 and prescription co-payments range from $10-50 depending on the type of prescription drug you are purchasing (generic vs. preferred).

Monthly Income	Monthly Premium
Less than $1,702	$60
$1,702-$1,194	$90
$1,915-$2,127	$110
$2,128-$2,339	$125
$2,340-$2,553	$135
More than $2,553	$380-390* *Subject to change

Q: Once someone enrolls in a Catamount Health, can they keep it as their health insurance plan forever?
A: If they enroll in Catamount Health without premium assistance (i.e., they purchase the product at its full price), they can keep Catamount Health as their insurance plan for as long as they want unless they become eligible for Medicaid or VHAP.

If they receive premium assistance to enroll in Catamount Health, there will be an annual process to review whether they are still eligible for premium assistance (i.e., are under 300 percent FPL), what level of premium assistance they are eligible for (i.e., which FPL bracket they are in), and if they have gained access to Employer-Sponsored Insurance (ESI), in which case, an assessment would be conducted to determine if it would be more cost-effective to the state to provide premium assistance for their ESI instead of Catamount Health. If the ESI plan is more cost-effective, the person would be required to enroll in ESI.

Q: How do I apply for Catamount Health?
A: Catamount Health will be available starting October 1, 2007. Call 1-800-250-8427 or visit http://hcr.vt.gov to learn more about Catamount Health.

Q: When can I enroll?
A: Open enrollment will be available beginning October 1, 2007.

Q: If I enroll in one Catamount Health Plan offered by x carrier and then decide I would rather enroll in the Catamount Health Plan offered by Y carrier, can I do this without any penalty or waiting period?
A: Nothing in the Catamount legislation prevents an insured from switching plans. However, you must understand what each carrier requires in order to terminate and apply for coverage. Processing applications takes time and a gap in coverage may expose you to liability for health care costs. Different carriers have different provider networks, benefit packages and chronic care management programs and you should understand the implications of these differences before you switch. If you are receiving premium assistance, you will need to communicate with OVHA to understand your notice obligations in order to retain your premium assistance.

CATAMOUNT HEALTH ELIGIBILITY

Q: Who can enroll in Catamount Health?
A: You can qualify for Catamount Health if you 1) Are a Vermont resident who is 18 years or older; 2) are currently not eligible for state health insurance programs such as Medicaid, VHAP and Medicare; 3) have been living without health insurance for at least 12 months (*unless* you lost insurance due to loss of employment, divorce from or death of a spouse, dis-enrolled from college or COBRA coverage ran out); and 4) do not have access to insurance through your employer or if the insurance offered does not cover hospital and physician services.

Q: I am currently insured but my premiums are more than I can afford. Can I sign up for Catamount Health?
A: No, you must be uninsured to enroll in Catamount Health. You would need to wait for 12 months after you cancel your insurance in order to be eligible for Catamount Health.

Q: I am self-employed and have my own private insurance. Can I qualify for Catamount Health?
A: No.

Q: Does being on VHAP count as having other insurance in the last 12 months?
A: No, publicly funded health care programs such as VHAP, Dr. Dynasaur, and Medicaid do not count as private insurance, so you would not have a waiting period if you apply for Catamount Health and/or premium assistance.

Q: What does “no longer receiving COBRA” mean in the definition of “uninsured”? Does it matter when and why I stopped receiving COBRA? What if I can’t afford the premiums for COBRA anymore?
A: You can choose to stop paying for COBRA coverage and are immediately eligible for Catamount Health.

Q: If someone’s hours were reduced at work and they no longer qualify for their employer’s insurance, will they have to wait 12 months before they can qualify for Catamount Health?
A: This issue is still under discussion.

Q: I am over 18 years old, but under age 21, and I’m not eligible for VHAP because my parents’ income is counted in the eligibility process. Can I get Catamount Health?
A: Your parents’ income would not disqualify you from enrolling in Catamount Health; however, if you applied for premium assistance for Catamount Health, your parents’ income would be counted. The income limit for Catamount Health with premium assistance is higher than for VHAP, so you might still qualify for premium assistance even if you don’t qualify for VHAP.

Q: Are people considered uninsured when they have a high-deductible health plan or a catastrophic care plan?
A: If someone is enrolled in a plan that offers physician and hospital coverage, they are not eligible for Catamount Health, no matter how high the deductible is. If someone has a catastrophic policy that covers only in-patient care (no physician), they would be considered uninsured and could therefore enroll in Catamount Health.

If someone who has been uninsured for 12 months applies for VHAP or Catamount Health premium assistance, the state can only require the person to enroll in an ESI plan if the deductible is $500 or less. If the deductible is higher than $500, the person would remain on VHAP (if under 150 percent of the FPL), or could enroll in Catamount Health with premium assistance (if between 150 & 300 percent of the FPL).

Q: If someone is uninsured for less than a year and then buys a catastrophic care plan for a combined total of 12 months, would they be eligible for Catamount Health?
A: No, because they would have had insurance for the past 2 months.

Q: What options are available to those who are classified as contractors?
A: Self-employed individuals who are uninsured, whether contractors or otherwise, are eligible for Catamount Health the same as any other individual.

Q: What is a Vermont resident?
A: Carriers will impose the same requirements for residency as presently applied. Generally, carriers require that you live in Vermont as your primary residence for at least six months out of the year.

Q: Once a student covered under their parent's MVP's Catamount plan turns 19, what are his/her options?
A: The student can apply to enroll in a Catamount plan as an individual.

Q: What if a University-sponsored plan is available to a student, but that student chooses not to enroll in the university plan? Is that student considered an "uninsured" eligible for Catamount?
A: Yes.

MEDICARE AND CATAMOUNT HEALTH

Q: Does Medicare eligibility affect eligibility for Catamount Health?
A: Yes, if you are not enrolled in Catamount Health and enroll in Medicare, you will not be eligible to enroll in Catamount Health. However, if you are already enrolled in Catamount Health and then become eligible for Medicare, you can choose to continue to stay enrolled in Catamount Health if you want to pay the full cost, since you will not be eligible for premium assistance. In this case, Medicare would be the primary payer and Catamount Health would be the secondary payer.

ACCESS TO CARE AND BENEFITS UNDER CATAMOUNT

Q: Is there a difference in the benefits offered through MVP and BCBS–VT?
A: Yes (see below for some of the differences. It is VERY IMPORTANT that you ask about differences important to your specific situation before choosing a Catamount Plan.

CATAMOUNT BENEFITS

Benefit Feature	*MVP*	*BCBSVT*
Pre-Authorization penalty	50%	100%
Concurrent review penalty	50%	100%
Lifetime Benefit Maximums:		
All Services	$1,000,000	$1,000,000
DME and Prosthetics	$25,000	No Maximum
Annual Benefit Maximum:		
Medical Foods	$2,500	No Maximum
DME and Prosthetics	Lifetime Maximum	$25,000
Skilled Nursing	120 days	100 days
Full-time students covered	No	Yes
Out-of-Network Preventive Care	No	Yes
Out-of-Network Home Health Care	No	Yes
Out-of Network Hospice Care	No	Yes
Out-of-Network Transplants	No	Yes
Out-of-Network RX	Yes	No

Q: Will I get an I.D card and certificate of coverage?
A: Yes.

Q: What aspects of coverage are not defined in the Catamount Health legislation?
A: "Acute episodic care" and "hospital services."

Q: What is the difference between in-network and out-of-network services?
A: In network services are those that are provided by health care practitioners that have contracts with your plan's carrier (MVP or BCBS-VT). Out-of-network services are provided by health care practitioners that do not have a contract with your plan's carrier, and therefore your annual deductible and out-of-pocket maximums are higher to use these services.

Q: Are referrals necessary for in-network or out-of-network services?
A: The insurance policies vary on which services require referral. Please note that it is your obligation to know what your Catamount Health Plan policy requires. Some services are not covered at all if you do not get the appropriate referral or prior authorization.

Q: Can I choose my own provider or doctor?
A: You can choose any provider or doctor that is in-network and pay the in-network co-pay. If you choose a provider or doctor that is not in the network for the plan, your annual deductible and out-of-pocket maximums are higher to use these services.

Q: Will all of BCBSVT/ MVP's current providers be part of their Catamount networks?
A: This has not yet been finalized.

Q: Do I have to go to Medicaid providers if I am on Catamount Health?
A: No.

Q: Do I need a primary care physician, and, if so, what kind of doctor or provider qualifies?
A: No. Neither carrier requires the use of a primary care physician in their plans, although the use of in-network/preferred providers is sometimes required for coverage of certain services.

Q: Will the reimbursement rate for providers be different than the current rates?
A: Possibly. They will be paid the lesser of a) the health care professional's standard contracted rate; b) the health care professional's billed charges; or c) the rate derived from the applicable 2006 Medicare fee schedule for Vermont, plus ten percent.

Q: If something happens to me while I am traveling, will I be covered through Catamount Health?
A: You should check with your carrier. The Catamount carriers have networks available outside of Vermont in many situations.

Q: How do I get information about services and providers, and how do I get problems resolved involving care or claims?
A: For questions about services and providers, or concerns about your coverage, you should call your insurance carrier at the number provided in your enrollment materials. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) takes formal complaints and answers questions about health insurance companies. BISHCA's consumer service number for complaints and inquiries about health insurance companies is 1-800-631-7788.

Q: Are lists of preferred drug plans different for MVP & BCBS – VT?
A: Yes, and they are subject to change.

Q: What is the appeal process for requesting non-formulary drugs?
A: It is the same as for any other private insurer.

Q: Are there annual or lifetime maximums for prescription drugs?
A: There is no annual maximum; lifetime maximum across all services is $1 million.

Q: Will drug co-payments count toward the annual out-of-pocket maximums?
A: No

Q: Are chronic condition management programs required to be offered by the carriers for every chronic condition?
A: No, only according to the Blueprint. If there is no management plan offered by the carrier, then there will be no cost-sharing waiver for that condition.

Q: Regarding the waiver of cost-sharing, what does "actively participating in a chronic care management program" mean - participating prior to Catamount, or actively participating once in Catamount or both?
A: Once in Catamount.

Q: Are there public hearings on the Catamount carriers' rates and forms filings?
A: No, but the filings are available pursuant to a public records request.

Q: Does Rule 10 apply to Catamount Health?
A: Yes

Q: Who is should be called concerning questions relating to Catamount, Premium Assistance, etc?
A: Depends on the question, but general questions should be directed to Maximus/Member Services or to the website (in development).

PRE-EXISTING CONDITIONS AND CATAMOUNT

Q: Can someone with a pre-existing condition enroll in Catamount Health?
A: Yes, with some conditions. Someone with a pre-existing condition cannot be denied for Catamount Health eligibility, but a person's pre-existing condition can be excluded from coverage for a 12-month period from the date of enrollment (pregnancy is not considered a pre-existing condition). There are two exceptions to this rule:

1. A carrier must waive any pre-existing condition provisions for all individuals and their dependents who produce evidence of continuous creditable coverage during the previous nine months, as long as the coverage occurred without a break in coverage of 63 or more days.
2. If a person is participating in a chronic care management program for a specific condition, that condition will not be excluded from coverage. Chronic care management for major chronic conditions is offered through Catamount Health. Most likely, the chronic conditions covered will expand as integration with the Blueprint moves forward over the next year or so.

Q: If someone is on Social Security disability and is not eligible for Medicare, will their disability be considered a pre-existing condition?
A: Yes.

Q: What is the definition of a pre-existing condition?
A: A condition for which you have received diagnosis or treatment in the past 12 months.

CATAMOUNT HEALTH PREMIUM ASSISTANCE

Q: What is Catamount Health Premium Assistance?
A: Depending on your household income, the state may help you pay for a portion of the monthly premium cost for enrollment in Catamount Health or in the health plan offered by our employer.

Q: How do I qualify for Catamount Health Premium Assistance and for what amount?
A: If you or your family's income is less than $2,553 a month, you may qualify for premium assistance. You must also meet one the following criteria:

1) You do not have access through your employer to insurance that has comprehensive benefits as determined by the state;
2) your employer's plan does have comprehensive benefits, but it costs the state less to give you premium assistance to enroll in a Catamount Health Plan than to provide premium assistance for you to enroll in your employer's plan or;
3) you are waiting for the open enrollment period to enroll in your employer's plan.

Q: How much will I have to pay?
A: Your share of the monthly premium is based on your income, so the lower your income, the less you have to pay. (Insert chart here)

Q: Will the premium cost of Catamount Health increase over time?
A: The unsubsidized cost of purchasing Catamount Health will increase each year as the carriers submit their rates to the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) based on previous years' experience. BISHCA will play an active role in reviewing these rates before they are approved.
The premium assistance subsidy amounts (for people under 300 percent of the federal poverty level (FPL)) are stated in law, and can only increase at a rate indexed to "the overall growth in spending per enrollee in Catamount Health." This cost will be adjusted annually.

Q: How much money can I make and still qualify for premium assistance?
A: Premium assistance is available to adults with income up to 300% of the federal poverty level. For a 1-person family, that's around $2750 per month. For a 2-person family, it's around $3650 per month, and for three people it's $4500 per month.

Q: If I own my home or have bank accounts, does that mean I wouldn't qualify for premium assistance?
A: No, there is no assets test for premium assistance, so your home or other real estate, bank accounts, cars, stocks or bonds, or other assets are not considered in the eligibility determination process.

Q: Can I get premium assistance if I am already insured?
A: No, you must have been uninsured for 12 months to be eligible for premium assistance, with some exceptions. For example, if you were insured through an employer and you lost your job, you would not have to wait 12 months to receive premium assistance.

Q: What if I had other insurance and lost it within the last 12 months?
A: You do not have to wait 12 months to apply for premium assistance if you lost your insurance because you lost a job, got divorced or your spouse died, you were covered under your parent's insurance plan and now you are too old to be covered under that plan, you were eligible for COBRA coverage but are not receiving it, or you left a college program.

Q: Is the amount of premium assistance I can receive for Catamount Health or for my employers' health insurance plan based on income, or income and assets?
A: The premium assistance amount you may receive under either premium assistance program will depend on your income (not income and assets).

Q: Can I get premium assistance for my children?
A: No, children in families with income less than 300% of the federal poverty level are eligible for Dr. Dynasaur.

Q: Can I drop my high-deductible insurance plan and sign up for Catamount Health premium assistance?
A: No, if you are enrolled in an insurance plan that includes both physician and hospital benefits, you do not qualify for premium assistance, even if you have a high deductible. If you drop your current insurance plan, you will have to wait 12 months before you would be eligible for premium assistance.

Q: I am self-employed. Can I get Catamount Health with premium assistance?
A: Yes, if you qualify based on your income.

Q: How do I enroll in premium assistance?
A: You can call the Member Service toll-free number at 1-800-250-8427. They will mail you an application form, or you may download an application form from our website at XXXXXXXX.

Q: Do I have to apply in person at a state office?
A: No, you can apply through the mail. You may receive a request by phone or by mail for additional information, but you will not have to appear in person at a state office.

Q: How is premium assistance paid?
A: If you are enrolled in your employer's insurance plan, premium assistance will be paid directly to you, and you will pay your employer through payroll deduction. If you are enrolled in Catamount Health, your premium will be paid directly to the insurance company, and you will pay a portion of that premium monthly to the state.

Q: Once I'm on premium assistance, will I have to keep filling out paperwork to stay on?
A: Your eligibility will be reviewed just once per year. Between reviews you must report any changes in your income, address, or number of people in your home.

CATAMOUNT HEALTH and EMPLOYER-SPONSORED INSURANCE

Q: Will I have a choice whether to enroll in my employer's health plan or in Catamount Health?
A: No, you must enroll in whichever plan is less expensive to the state.

Q: Is the amount of premium assistance I can receive for Catamount Health or for my employers' health insurance plan based on income, or income and assets?
A: The premium assistance amount you may receive under either premium assistance program will depend on your income (not income and assets).

Q: Can people receiving premium assistance move between Catamount Health and their Employer-Sponsored Insurance (ESI) depending on their circumstances?

A: If someone is on premium assistance and then gains access to ESI, the can continue to get premium assistance if their income remains below 300 percent of the federal poverty level. The state will conduct an analysis to determine whether it is more cost-effective to provide premium assistance to enroll in ESI or to stay on Catamount Health.

Q: If someone was originally enrolled in Catamount Health and then the state determines that it is more cost-effective to provide premium assistance for their ESI instead of Catamount Health, can the person ever return to Catamount Health if they lose their ESI?
A: If a person is enrolled in ESI premium assistance and loses eligibility for the ESI plan, he or she may enroll in Catamount Health, and depending on income level at that point, receive premium assistance.

If a person is enrolled in ESI without premium assistance and loses eligibility for ESI, he or she may enroll in Catamount Health only if the loss of ESI eligibility was for a reason allowable under the law (e.g., death of or divorce from the policy holder or loss of employment). If one of the exceptions is not met, the person must be uninsured for 12 months to qualify for Catamount Health.

Q: What if I'm receiving premium assistance for my employer's insurance plan, and the plan won't pay for some services I need?
A: If you are also in VHAP, VHAP will provide a "wrap-around" benefit to your employer's plan. VHAP will pay for services your insurance plan doesn't pay, as long as the services are covered by VHAP. If you are not in VHAP, the state will pay for services for some chronic conditions.

SPOUSE'S INSURANCE AND PREMIUM ASSISTANCE

Q: My husband has insurance through his employer. Can I apply for Catamount Health premium assistance?
A: You may apply for premium assistance. The state will ask you to provide information on your husband's insurance plan. If he can enroll you in his insurance plan, and if it is less costly to the state to provide premium assistance to you in your husband's insurance plan than to provide premium assistance to you for Catamount Health, you will be required to enroll in your husband's plan.

Q: If I cannot afford the insurance they have now through my spouse's employer, can I qualify for premium assistance to help pay for it?
A: Yes, if your husband is enrolled in his employer's insurance plan, you can apply for premium assistance to enroll in his plan. If it is less expensive to the state to enroll you in your husband's plan than to enroll you in Catamount Health, you can receive premium assistance to enroll in your husband's plan. Otherwise, you can receive premium assistance to enroll in Catamount Health.

RETIREES AND CATAMOUNT HEALTH

Q: Are retirees who are eligible for company-sponsored retiree health insurance eligible for Catamount Health ESI?
A: A retiree who is eligible for company-sponsored retiree health insurance is considered to be eligible for an employer-sponsored insurance plan (per 8 V.S.A. § 4080f (d)(1)). Therefore, they cannot enroll in Catamount Health unless they have incomes at or under 300 percent of the federal poverty level, apply for premium assistance, and it is more cost effective for the state to pay premium assistance for ESI rather than Catamount Health.

Q: I am retired and have access to an insurance plan through my former employer; however, I would rather have Catamount with premium assistance. Can I sign up for Catamount?
A: You can only apply for Catamount Health with premium assistance if your income is at or below 300 percent of the FPL. The state will compare the cost of your former employer's health plan to the cost of Catamount Health and require that you enroll in the plan that is least expensive for the state regarding your premium payments.

Q: Do retirees have to enroll in their company-offered retiree plan, and then, based on income, apply for premium assistance?
A: Yes. If the state determines that the ESI plan is approved as comprehensive and affordable, and it is more cost effective for the state to pay premium assistance to enroll in ESI rather than Catamount Health, the applicant will be required to enroll in ESI in order to receive premium assistance. In addition, retirees are considered the same as employees in this instance.

Q: Can retirees enroll in Catamount Health and receive premium assistance based on their income without regard to the contribution to premium coverage offered by the employer?
A: The cost-effectiveness test for providing premium subsidies to enroll in either Catamount Health or their employer's plan will take into account the contribution to premium coverage offered by the employer.

Q: What portion of a retiree's income would be used to determine the amount of the subsidy, if any, available if the retiree enrolls in an employer's retiree health plan?
A: In general, the person's total income is the basis for this determination. However, the premium assistance eligibility determination will use VHAP rules, which allow some deductions from income.

Q: If a retiree who is eligible for retiree health insurance secures employment with another company which offers health insurance, how does that change the employee's options and the company's obligations?
A: If the retiree has two ESI plans available, and the retiree is eligible for premium assistance, the state would evaluate both plans for cost-effectiveness. If one plan is cost-effective and the other plan is not, the retiree would be required to enroll in the cost-effective plan. If both plans are cost-effective, the retiree could choose either plan. If neither plan is cost-effective, the retiree could enroll in Catamount Health with premium assistance.

VHAP AND CATAMOUNT HEALTH

Q: Does VHAP count as having insurance within the last 12 months?
A: The 12-month waiting period applies only to Catamount Health applicants who had private insurance in the last 12 months. VHAP is not private insurance, and enrollment in VHAP would not result in a 12-month waiting period for Catamount Health.

Q: Will I be eligible for Catamount Health if I closed on VHAP within the last 12 months due to failure to pay premiums or requested closure?
A: No, the reason you lost VHAP coverage would not affect your eligibility for Catamount Health.

Q: If I purchase a Catamount Health plan, can I switch to VHAP if my income drops or do I have to be uninsured for 12 months under the VHAP rules? Does it make a difference if I receive premium assistance or not?
A: You can switch from Catamount Health to VHAP without having to wait 12 months. Whether or not you were receiving premium assistance does not affect your eligibility for VHAP.

Q: Will the rules for students that apply to VHAP also apply to Catamount Health?
A: No, you may apply for Catamount Health if you are not enrolled in the insurance plan offered by your school, and you do not have to be working 20 hours per week to qualify for Catamount Health.

Q: How does it work if I am in VHAP and my employer's health plan?
A: You will have two cards, a VHAP card and a private insurance card. You must choose providers that accept VHAP patients and who are in the private insurance provider network. You must show both your cards when you receive services.

PREMIUM ASSISTANCE AND EMPLOYER CONTRIBUTION ASSESSMENT

Q: If an employee gets a state subsidy to enroll in Catamount Health ESI or premium assistance, or if they are enrolled in Medicaid or VHAP, does this employee count towards the full-time equivalent (FTE) that the employer must include in their Employer Health Care Contribution payment calculations?
A: Employees who receive ESI premium assistance are participating in the employer's plan, so they would not be included in the FTE calculation.

Any employee whose health coverage is <u>not</u> supported in some way by the employer must be included in the FTE calculation with one exception. The exception is for employees who refuse to participate in the employer's plan and have other coverage. The only scenario where an employee would have Catamount coverage when the employer offers coverage is if the employee has an income at or below 300 percent FPL and the state has concluded that

providing assistance to the employee to enroll in the Catamount Health is less costly than providing assistance to enroll in their ESI plan.

Under this scenario, the employee would be considered to have coverage for purposes of the Employer Health Care Contribution calculation. Employees with incomes over 300 percent FPL cannot enroll in Catamount Health if they have access to approved Employer-Sponsored Insurance.

If an employer offers coverage and an employee refuses coverage and s/he is enrolled in VHAP (with or without premium assistance) or enrolled in Medicaid, this employee should NOT be included in the Employer Health Care Contribution calculation because they have coverage.